Confirmation of Annual Exam by Medical Doctor

Last Name: _____ **First Name:** _____

Date of Birth: _____

The patient named above has registered to attend an overnight summer camp program with the Autism Society of Minnesota. Parents have completed an online medical history, including diagnoses, prescribed medications, and treatment protocols. We are asking your clinic to confirm that this camper has been examined by a licensed physician or nurse practitioner within the previous twelve (12) months.

Date of last physical exam: _____ Height: _____ Weight: _____

Does this camper have any activity restrictions? Y _____ N _____

Please share any concerns you have with this person attending an ACA-certified summer camp.

Provider Name: _____

Provider Signature: _____

Date: _____

Provider Phone: _____

Please return this form to the patient or send directly to the Autism Society of Minnesota.

Email: camp@ausm.org

Phone: 651.647.1083

Fax: 651.642.1230